No. 89-682

In The

Supreme Court of the United States

October Term, 1989

THE STATE OF COLORADO DEPARTMENT OF SOCIAL SERVICES, and IRENE M. IBARRA, Executive Director of the State of Colorado Department of Social Services,

Petitioners,

v.

AMISUB (PSL), d/b/a AMI St. Luke's Hospital, Inc., AMI Presbyterian Denver Hospital, Inc., and AMI Presbyterian Aurora Hospital, Inc.,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

DUANE WOODARD
Attorney General

CHARLES B. HOWE
Deputy Attorney General

RICHARD H. FORMAN
Solicitor General

MARY ANN F. WHITESIDE
First Assistant Attorney General
Counsel of Record

WADE LIVINGSTON
First Assistant Attorney General
Human Resources Section

Attorneys for Petitioner

1525 Sherman Street, 3d Floor
Denver, Colorado 80203
Telephone: (303) 866-3611

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

ISSUES PRESENTED FOR REVIEW

Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. § 1983 to enforce the Medicaid Act against a State.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

Cases

Statutes

OPINIONS BELOW

The opinion of the United States District Court for the District of Colorado is not reported and is set forth in the Appendix at App. 1. The opinion of the United States Court of Appeals for the Tenth Circuit is reported at 879 F.2d 789 and is set forth in the Appendix at App. 11.

JURISDICTION

The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1) (1982). The decision of the Court of Appeals was rendered on July 11, 1989, and the petition for rehearing with suggestion for rehearing *en banc* was denied August 31, 1989.

STATUTORY PROVISION INVOLVED

42 U.S.C. § 1396a(a)(13)(A) (1986) provides, in pertinent part:

> A state plan for medical assistance must . . . provide . . . for payment . . . of the hospital . . . services provided under the plan through the use of rates . . . which the state finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards. . . .

STATEMENT OF THE CASE

Respondents, three hospitals participating in the Colorado Medicaid Program ("Hospitals"), filed an action challenging the rates they received for treating Medicaid patients. The Hospitals claimed the rates were not in accordance with 42 U.S.C. § 1396a(a)(13)(A) (1986) and invoked the jurisdiction of the District Court under 42 U.S.C. § 1983 (1982).

Following a trial to the bench, the District Court entered an opinion and order (App. 1-10) upholding the Medicaid rates established by petitioner State of Colorado Department of Social Services ("Department"). In brief, the District Court held that the Department had not acted arbitrarily or capriciously by establishing Medicaid rates based upon hospital costs discounted by a factor to keep the rates within historical payment levels to hospitals (App. 9-10).

On appeal, the Tenth Circuit reversed (App. 11-39). It held that the Hospitals have rights under 42 U.S.C. § 1396a(a)(13)(A) (1986) which are enforceable through a private action under 42 U.S.C. § 1983 (1982). The Tenth Circuit further held that the Department's practice of discounting hospital rates to keep them within historical payment levels violated federal law and prohibited the Department from discounting the rates as of the date of its opinion. The Tenth Circuit denied the Department's petition for rehearing with suggestion for rehearing *en banc*, but granted the Department's motion for stay of mandate pending application to this court for a writ of certiorari.

REASONS WHY THE PETITION FOR A WRIT OF CERTIORARI SHOULD BE GRANTED.

The court below has issued a decision on an important question of federal law which has not been, but should be, decided by this Court. This Court recognized the importance of this very question when it granted certiorari to review the decision of the Ninth Circuit in *Coos Bay Center v. State of Oregon, Department of Human Resources*, 803 F.2d 1060 (9th Cir. 1986), *judgment vacated on issue of mootness*, 108 S. Ct. 52 (1987) and, more recently, when it granted certiorari to review the Fourth Circuit's decision in *Virginia Hospital Association v. Baliles*, 868 F.2d 653 (4th Cir.), *cert. granted*, No. 88-2043 (Oct. 10, 1989).

The costs of, and the demand for, publicly funded health care have increased dramatically in the recent past. Under the decision of the court below, the important policy decisions regarding payment for these health care services will be dictated by the federal courts rather than by the states, with oversight from federal administrative agencies, as Congress intended. There is no express right of action under the Medicaid statutes but the court below has, nevertheless, determined that providers can use 42 U.S.C. § 1983 (1982) as a tool of first resort to resolve any dispute they may have with a state regarding Medicaid rates. This decision has such a dramatic impact on a wide range ot vital public issues that it should be decided by this Court.

It is ironic that the court below should have found this implied private right of action in the language of a statute expressly intended to *reduce* federal oversight of state Medicaid plans. *Wisconsin Hospital Association v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984). The statute

does not contain any "right-or-duty creating language." *Cannon v. University of Chicago*, 441 U.S. 677, 690 n.13 (1979). On the contrary, the statute only requires states to make "assurances satisfactory to the Secretary" of Health and Human Services, the federal agency which oversees the Medicaid program. 42 U.S.C. § 1396a(a)(13)(A) (1986). It seems clear that Congress intended the question of whether Medicaid rates are satisfactory to be determined by the Secretary, not by the courts. Accordingly, no federal right of action should be implied. See *Wright v. Roanoke Redevelopment & Housing Authority*, 479 U.S. 418 (1987).

CONCLUSION

The court below decided an important issue of federal law, affecting the vital area of publicly funded health care. The decision found an implied right of action where the implication cannot be supported from either the language or the intent of the statute. Accordingly, the petition for a writ of certiorari should be granted.

FOR THE ATTORNEY GENERAL

MARY ANN F. WHITESIDE
Counsel of Record

WADE LIVINGSTON
First Assistant Attorney General
Human Resources Section

Attorneys for Petitioners

1525 Sherman Street, 3d Floor
Denver, Colorado 80203
Telephone: (303) 866-3611

APPENDIX

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 88-F-1024

AMISUB (PSL), INC., d/b/a AMI ST. LUKE'S HOSPITAL, AMI PRESBYTERIAN DENVER HOSPITAL, INC., and AMI PRESBYTERIAN AURORA HOSPITAL, INC.,

Plaintiffs,

vs.

THE STATE OF COLORADO DEPARTMENT OF SOCIAL SERVICES, and IRENE M. IBARRA, EXECUTIVE DIRECTOR OF THE STATE OF COLORADO, DEPARTMENT OF SOCIAL SERVICES,

Defendants.

JUDGMENT
(Filed September 14, 1988)

Pursuant to and in accordance with the order of Chief Judge Sherman G. Finesilver dated September 14, 1988, it is

ORDERED that judgment is entered in favor of the Defendants and against the Plaintiffs. It is further

ORDERED that the action and complaint are hereby dismissed. It is further

ORDERED that the Defendants shall have their costs upon their filing of a Bill of Costs. Bill of Costs shall be filed within 10 days of this judgment.

DATED at Denver, Colorado this 14th day of September, 1988.

FOR THE COURT:
JAMES R. MANSPEAKER, CLERK

By: /s/ Stephen P. Ehrlich
Stephen P. Ehrlich
Chief Deputy Clerk

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Action No. 88-F-1024

AMISUB (PSL), INC., d/b/a AMI ST. LUKE'S HOSPITAL, AMI PRESBYTERIAN DENVER HOSPITAL, INC., AND AMI PRESBYTERIAN AURORA HOSPITAL, INC.,

Plaintiffs,

vs.

THE STATE OF COLORADO DEPARTMENT OF SOCIAL SERVICES, and IRENE M. IBARRA, EXECUTIVE DIRECTOR OF THE STATE OF COLORADO, DEPARTMENT OF SOCIAL SERVICES,

Defendants.

Sherman G. Finesilver, Chief Judge

ORDER

(Filed September 14, 1988)

This matter comes before the court on a trial to the court on the merits. Plaintiffs challenge the State of Colorado's system for reimbursment of Medicaid costs to hospitals. Plaintiffs argue that the State Plan violates 42 U.S.C. § 1396a(a), because the State Plan does not provide for meeting the reasonable costs of hospitals which serve Medicaid patients. Jurisdiction is proper before this court under 28 U.S.C. § 1331.

The court has examined the pleadings, briefs and argument of counsel, and enters these findings of fact and conclusions of law.

FINDINGS OF FACT

1. Plaintiff hospitals are duly licensed by the State of Colorado to provide acute care hospital services. Plaintiff hospitals also participate in the Colorado Medicaid program as providers of inpatient hospital services. Plaintiff hospitals function as tertiary care centers for the Denver area.

2. Defendant Irene M. Ibarra is the Executive Director of the State Medicaid Agency. Defendant State of Colorado Department of Social Services is the single State agency designated by the federal government to administer the Medicaid program in Colorado.

3. Title XIX of the Social Security Act, 42 U.S.C. § 1397-1397f, the Medicaid law, authorizes federal grants to States for medical assistance to low-income persons who are aged, blind, disabled, or members of families with dependant children. The program is jointly financed by the federal and state governments and administered by the States. The States, in accordance with federal law, decide eligible beneficiary groups, types and ranges of services, payment level for services, and administrative and operative procedures. Payment for services are made directly to the individuals or entities that furnish the services. 42 C.F.R. § 430.0

4. For hospital admissions occurring on or after July 1, 1988, the State Medicaid Agency has implemented a Diagnostically Related Group (DRG) type system for reimbursing Colorado hospitals for providing inpatient hospital services to Medicaid beneficiaries. The system

calls for classifications of ailments or hospitalizations, each of which is assigned a relative weight. When a hospital has treated a Medicaid patient, the relative weight is multiplied by a base rate to determine the payment to the hospital. Plaintiff hospitals do not challenge the DRG system itself, or the relative weights assigned to each DRG. Rather, they challenge the base rates.

5. A different base rate was determined for each of three peer groups of hospitals: (a) urban hospitals, (b) rural hospitals, and (c) rural referral centers. Therefore, hospitals within each peer group are assumed to have similar costs. In addition, a Base Rate is defined for out-of-state hospitals.

6. The base rates were computed as follows: First, reimbursable Medicare costs are determined through reasonable cost standards set forth in 42 U.S.C. § 1395X (v) (1) (A) and 42 C.F.R. § 413.1 et seq. Not all actual costs incurred by hospitals are allowable costs under these Medicare reasonable cost principles. Moreover, Allowable Costs are only reimbursed to the extent they are reasonable in amount. To calculate the Medicaid base rate for each peer group under 10 C.C.R. 2505-10, § 8.356.20, an average Medicare reimbursable cost per discharge for each peer group is calculated. This average is based on the total costs obtained from the peer group hospitals' most recently audited Medicare/Medicaid cost reports (currently the 1985 reports) divided by the number of Medicare discharges for each hospital. The Medicare allowable costs of each hospital are adjusted to neutralize

cost differences between hospitals in the peer groups resulting from differences in the severity of the conditions of the Medicare patients treated at each hospital. The peer group hospitals' average Medicare cost per discharge obtained from the 1985 cost report is updated by an inflation factor (currently approximately 3% per year) to reflect current input prices. Then, the Medicare average cost per discharge is multiplied by .88 to obtain the Medicaid average cost per discharge (thus assuming that Medicaid costs are lower than Medicare costs).

7. Finally, the State Medicaid Agency multiplies the figure obtained above by .54 (that is, reduces it by 46%). The .54 figure is known as the final adjustment factor, and is based on the sums historically appropriated by the State legislature for Medicaid payment for inpatient hospital services. It is the ratio of the Legislature's budget appropriation to the figure obtained through the process described in the last paragraph. Thus, the figure has no relation to the actual costs of hospital services.

8. The Colorado State Legislature has appropriated $57,427,405 for reimbursing inpatient hospital services for the fiscal year beginning July 1, 1988 (fiscal year 1989). Of that sum, approximately $41,000,000 is projected to be paid for hospital services covered by the new DRG system. Because the total sum to be paid for inpatient hospital services is limited to the total sum appropriated by the State Legislature, there will have to be a concomitant decrease in payments to other categories of inpatient hospital services if payments in any category exceed the sums projected, unless the State Legislature appropriates

supplemental funds. The State Medicaid Agency has also requested permission from the Legislature to overspend its 1988 fiscal year budget for inpatient hospital services since the sum appropriated for that year did not cover the actual amounts required to be paid to providers under the previous system for reimbursing providers of inpatient hospital services. If permission to overspend is granted, the additional funds will be paid out of the 1989 fiscal year appropriation. The amount to be paid be the State Medicaid Agency to all hospital providers exclusive of the final adjustment factor is projected to exceed $106,000,000 for services provided to Medicaid patients during the 1989 fiscal year. If the number of Medicaid patients exceeded projections, this sum would increase.

9. Because the final adjustment factor reduces the figure obtained through the process in paragraph 7, which roughly represents costs to the hospitals of providing Medicaid patient care, by 46%, no Colorado hospital recovers its actual costs from the Medicaid program. Some of these Colorado hospitals are efficiently and economically operated.

10. The new DRG system effective July 1st, 1988 was intended to be budget neutral by the State Medicaid Agency. The system is not intended to save state revenues, but only to be a more realistic mechanism for distributing Medicaid reimbursements.

11. The State Plan relies on expenditure levels from previous years to determine the level of expenditure for the current year. Since Medicaid reimbursements under

the new system are substantially identical to reimbursements in previous years, it has not been demonstrated that the new system would result in a loss of Medicare patient access to medical care in Colorado.

12. Under the Medicaid law, each State is required to submit for approval by the Health Care Financing Administration ("HCFA") a State Plan for the provision of medical assistance to eligible beneficiaries. 42 U.S.C. § 1396. The State Plan must comply with the requirements of 42 U.S.C. § 1396a and the applicable federal regulations with respect to the setting of Medicaid payment rates. 42 C.F.R. § 447.200. Modification of payment rates requires a State Medicaid Agency to develop a State Plan Amendment which must be approved by HFCA. 45 C.F.R. § 205.5.

13. Under 42 U.S.C. Section 1396a (a) (13) (A) a State Plan must, *inter alia*, provide for payment for hospital services through the use of rates which the State finds are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities in the provision of services in conformity with applicable State and Federal laws. *See also* 42 C.F.R. Section 447.204. The State Plan must be satisfactory to the HFCA.

14. HFCA's review of the proposed State Plan is cursory. They do not review the State Medicaid Agency's standards of payment or actual payment rates. Rather, the inquiry is limited to a determination of whether the documentation submitted by the State Medicaid Agency complies with procedural requirements.

CONCLUSIONS OF LAW

1. Since the review of this court of the State Medicaid Plan covers matters not considered by the HFCA, the doctrine of primary jurisdiction does not require this court to defer ruling on the merits of the plaintiffs' claim until after HFCA has made its determination. The plaintiffs do not ask us to review the assurances made to the HFCA, but only the validity of the State Medicaid Agency's findings.

2. The review of this court is limited to the issue of whether the findings of the State Medicaid Agency were arbitrary and capricious. *Colorado Health Care Assoc. v. Colorado Department of Social Services*, 842 F.2d 1158, 1164 (10th Cir. 1988).

3. The fact that the State Medicaid Agency adjusted repayment rates according to State budgetary constraints does not invalidate the agency's findings. In *Colorado Health*, the Tenth Circuit Court of Appeals construed the same provision of law at issue here, 42 U.S.C. § 1396a (a) (13) (A). *Id.* at 1165. The court held that states can consider budgetary constraints as a factor in amending Medicaid payment methods. *Id.* at 1168. Similarly, the State Medicaid Agency is entitled to rely on budgetary considerations in setting repayment rates.

4. The State's method of determining repayment rates, which essentially relies on an extrapolation from the expenditures from past years, is also legitimate. While the system may not be perfect, it is not arbitrary and

capricious. Furthermore, the fact that no Colorado hospital recovers its costs from the reimbursment (sic) program does not make the system arbitrary and capricious.

ACCORDINGLY, the court finds that the defendants have not violated federal law. The court directs the Clerk to enter judgment in favor of defendants and against plaintiff. It is further ordered that defendants have their costs of action.

Done this 13 day of September, 1988 at Denver, Colorado.

By the Court:

/s/ Sherman G. Finesilver
Sherman G. Finesilver, Chief Judge
United States District Court

PUBLISH

UNITED STATES COURT OF APPEALS

TENTH CIRCUIT

AMISUB (PSL), INC., d/b/a/ AMI ST. LUKE'S HOSPITAL, INC., AMI PRESBYTERIAN DENVER HOSPITAL, INC., and AMI PRESBYTERIAN AURORA HOSPITAL, INC., Plaintiffs/Appellants, v. THE STATE OF COLORADO DEPARTMENT OF SOCIAL SERVICES, and IRENE M. IBARRA, EXECUTIVE DIRECTOR OF THE STATE OF COLORADO, DEPARTMENT OF SOCIAL SERVICES, Defendants/Appellees.	No. 88-2482

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLORADO
(NO. 88-F-1024)

(Filed July 11, 1989)

Patric Hooper (L. Richard Freese, Jr., and Sharon E. Caulfield of Davis, Graham & Stubbs, Denver, Colorado, with him on the briefs), Hooper, Lundy & Bookman, Inc., Los Angeles, California, for Plaintiffs/Appellants.

Wade S. Livingston, Assistant Attorney General (Duane Woodard, Attorney General, Charles B. Howe, Deputy Attorney General and Richard H. Forman, Solicitor General, with him on the brief) State of Colorado, for Defendants/Appellees.

Wayne J. Fowler of Saunders, Snyder, Ross & Dickson, P.C., Denver, Colorado, on the briefs for Amicus Curiae American Hospital Association and Amicus Curiae Colorado Hospital Association; Michael F. Anthony, Jeffrey M. Teske, Lawrence E. Singer, Chicago, Illinois, on the brief for Amicus Curiae American Hospital Association.

Before ANDERSON, BARRETT, and BRORBY, Circuit Judges.

BRORBY, Circuit Judge.

Plaintiffs, three licensed Colorado hospitals (hereinafter "appellants" or "Hospitals") appeal from a final judgment against them. As Medicaid providers, they challenged the State of Colorado's system for reimbursement of inpatient hospital services as violative of 42 U.S.C. § 1396 *et seq.* (1989 Supp.) (hereinafter "Medicaid Act"). On appeal, appellants allege the district court had jurisdiction based on 28 U.S.C. § 1331, 28 U.S.C. § 1361, and 42 U.S.C. § 1983. The district court correctly held jurisdiction was based on 28 U.S.C. § 1331 since plaintiffs were challenging Colorado's compliance with the Medicaid Act in a 42 U.S.C. § 1983 action.[1] We are in accord with the district court on the jurisdictional basis, and, furthermore, hold that 28 U.S.C. § 1361 (1976), the federal

---

[1] Appellants may be confused on this issue because the Joint Pre-Trial Order stated that 28 U.S.C. § 1361 was a jurisdictional basis.

mandamus statute, is not a jurisdictional basis in this case. The named defendants in the district court and appellees here are the State of Colorado Department of Social Services (CDSS) and Irene M. Ibarra, its Executive Director. No relief against state officials or state agencies is afforded by § 1361.[2]

On appeal, appellants present the following issues:

> 1. Did the District Court improperly limit its review of the agency decision by determining *only* whether the Medicaid payment rates in question were arbitrarily and capriciously established?
>
> 2. Were the Medicaid payment rates in question established by Appellees ("the State Medicaid Agency") in accordance with the procedures required by the governing federal Medicaid statute and regulations?
>
> 3. Are the Medicaid payment rates in question authorized by and consistent with the governing federal Medicaid statute and regulations?
>
> 4. Are the Medicaid payment rates in question established by the State Medicaid Agency arbitrary and capricious?

In response, the appellees contend that (1) the Hospitals have no statutory right to a particular Medicaid rate,

---

[2] 28 U.S.C.A. § 1361 (1976) grants federal courts "jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff." Although this jurisdictional grant may apply to the federal Medicaid agencies – the Department of Health and Human Services (DHSS), and the Health Care Financing Administration (HCFA) – it does not apply to the state defendants.

i.e., "42 U.S.C. § 1396a(a) (13) (A) is not the kind of statute that creates enforceable rights under 42 U.S.C. § 1983"; (2) the Hospitals are not the "intended beneficiaries of the federal medicaid statutes"; (3) the reimbursement rates set by CDSS are not arbitrary and capricious; and (4) CDSS made the "findings" and "assurances" required by federal law.

First, we hold that, pursuant to 42 U.S.C. § 1396 *et seq.*, the Hospitals have enforceable rights under 42 U.S.C. § 1983; second, we hold that the Hospitals have standing to challenge the reimbursement rates under the Colorado Medicaid Plan; third, we hold that the district court improperly limited its review of the agency decision by determining *only* whether the Colorado reimbursement plan was arbitrary and capricious; fourth, the Colorado Medicaid payment rates were not in accordance with the *procedures* required by the federal Medicaid statute and regulations; fifth, the Medicaid reimbursement rates as established are violative of federal law; and sixth, the Medicaid payment rates as established are arbitrary and capricious.

Therefore, we REVERSE the district court. We declare the reimbursement rates to be in violation of federal law and prohibit their usage.

I.

FACTS

Effective July 1, 1988, the Colorado Medicaid Agency (CDSS) implemented a new provider reimbursement plan. 10 C.C.R. 2505-10, § 8.356 (1988). The new plan

employs diagnostically related groupings (DRG's) to pay providers prospectively determined rates based on the Medicaid patient's discharge diagnosis. The system classifies ailments or hospitalizations according to the discharge diagnoses and assigns to them a relative weight, which reflects relative resource consumption. When a provider has treated a Medicaid patient, the relative weight is multiplied by a base rate. A different base rate was determined for three peer groups of hospitals: (a) urban hospitals, (b) rural hospitals, and (c) rural referral centers. Hospitals within each group are presumed to have similar costs.

To compute base rates, the new Colorado Medicaid plan employs the following steps: Reimbursable *Medicare* costs are determined by cost standards in 42 U.S.C. § 1395x(v) (1) (A) (1983) and 42 C.F.R. § 413.1 *et seq.* (1987). Medicare reasonable costs do not encompass actual costs, but rather provide standards for reasonable allowable costs for provider reimbursement, i.e., only allowable costs which are reasonable in amount are reimbursable. To calculate the *Medicaid* base rate, an average *Medicare* reimbursable cost per discharge for each peer group is calculated. Then, the average *Medicare* cost per discharge is multiplied by .88 to determine the Medicaid average.[3] Thus, the calculation presumes that Medicaid patients, in general, incur only 88% of the medical costs of Medicare patients with the same ailment. Finally, CDSS multiplies the .88 reduced payment by .54, i.e., it reduces

---

[3] MEDICARE REASONABLE ALLOWABLE COST x .88 = MEDICAID REASONABLE ALLOWABLE COST

provider reimbursement by 46%.[4] The .54 is known as the budget adjustment factor (BAF), and is based solely on the sums historically and currently appropriated by the Colorado legislature for provider reimbursement for inpatient hospital services. The BAF resulting in a 46% decrease in provider reimbursement rates "has no relation to the actual costs of hospital services."

Because the BAF reduces provider reimbursement by 46%, the district court properly found that "no Colorado hospital recovers its actual costs." In addition, it properly found that "[s]ome of these Colorado hospitals are efficiently and economically operated."

II.

PRELIMINARY ISSUES

Before we reach the merits of the case, we must address three preliminary issues: (1) whether this suit is barred by the Eleventh Amendment;[5] (2) whether 42 U.S.C. § 1396 *et seq.* creates enforceable rights under 42 U.S.C. § 1983; and, (3) appellants' standing to challenge Colorado's Medicaid plan. We address these issues at the start since any one of them could dispose of the case *in toto*.

---

[4] MEDICARE REASONABLE ALLOWABLE COST x .88 x .54 = ACTUAL PROVIDER REIMBURSEMENT

[5] We raise the Eleventh Amendment issue *sua sponte*. Appellees raised the defense in the Pre-Trial Order, but did not address it in their brief.

A. Eleventh Amendment

In addition to Irene M. Ibarra, Executive Director of the State of Colorado, Department of Social Services, the hospitals have named the State of Colorado, Department of Social Services, as defendant. As previously noted, we raise the Eleventh Amendment issue *sua sponte*.

In this case, we must decide whether the State of Colorado may be subject to suit in federal court for alleged violations of the Medicaid Act. The State presents no arguments in support of its Eleventh Amendment defense, presumably resting on its bald assertion of the defense in the Pre-Trial Order. The district court was completely silent on the issue. However, we must address it since the Eleventh Amendment may be a jurisdictional bar to this court with respect to the State of Colorado as named defendant.

The Eleventh Amendment provides:

> The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

Even though the clear language does not so provide, the Eleventh Amendment has been interpreted to bar a suit by a citizen against the citizen's own State in Federal Court. *Hans v. State of Louisiana*, 134 U.S. 1, 10 (1890). In essence, the fundamental principle of sovereign immunity embodied in the Eleventh Amendment limits the grant of federal jurisdiction in Article III. *Welch v. Texas Dept. of Highways and Pub. Transp.*, 483 U.S. 468, 472, 107

S.Ct. 2941, 2945 (1987), *citing Pennhurst State School & Hosp. v. Halderman*, 465 U.S. 89, 98 (1984).

The sovereign immunity afforded by the Eleventh Amendment is not absolute. In *Clark v. Barnard*, 108 U.S. 436, 447 (1883), the Supreme Court held that if a State waives immunity and consents to suit in federal court, the Eleventh Amendment is not a bar. However, a State may waive immunity "only where stated 'by the most express language or by such overwhelming implications from the text as [will] leave no room for any other reasonable construction.'" *Edelman v. Jordan*, 415 U.S. 651, 673 (1974) (quoting *Murray v. Wilson Distilling Co.*, 213 U.S. 151, 171 (1909)). Furthermore, "constructive consent" is not sufficient to overcome sovereign immunity. *Edelman*, 415 U.S. at 673. In addition, the Supreme Court has held that Congress may abrogate Eleventh Amendment sovereign immunity without the State's consent. *Fitzpatrick v. Bitzer*, 427 U.S. 445, 456 (1976). However, "Congress must express its intention to abrogate the Eleventh Amendment in unmistakable language in the statute itself." *Atascadero State Hosp. v. Scanlon*, 473 U.S. 234, 243 (1985). *A fortiori*, the Supreme Court will not *infer* Congressional abrogation of the Eleventh Amendment. *Pennhurst*, 465 U.S. at 99.

In this case, the State of Colorado raised the Eleventh Amendment defense at the district court level. Despite the fact that its reply brief is silent on the issue, we cannot say that this is an effective waiver to satisfy the standard in *Edelman*. The State has not "expressly stated" by its silence that it has waived Eleventh Amendment immunity. Neither can we say that participation in this suit is an effective waiver. In *Ford Motor Co. v. Department*

of Treasury of State of Ind., 323 U.S. 459, 466-67 (1945), the State of Indiana, by its Attorney General, appeared in the federal district court and the circuit court of appeals and defended the suit on the merits. The Eleventh Amendment issue was addressed for the first time by the Supreme Court and held to be a bar. *Id.* at 468. Thus, we hold that the State of Colorado's participation in this suit is not an effective waiver of its sovereign immunity.[6]

Next we consider whether Congress has abrogated the States' sovereign immunity by "unmistakable language" in the Medicaid Act to satisfy the standard in *Atascadero*. We find no such "unmistakable language" in the Act.

Therefore, we hold that the Eleventh Amendment is a bar to the suit against the State of Colorado, Department of Social Services, and, hereby, dismiss the State as named defendant. However, because the district court properly had jurisdiction over Irene M. Ibarra, as Executive Director,[7] the case is properly before us, and we will proceed to the merits.

---

[6] In *Clallam Cty. v. Department of Transp. of the State of Wash.*, 849 F.2d 424, 426-27 (9th Cir. 1988), *cert. denied*, 109 S.Ct. 790 (1989), the Ninth Circuit dismissed the State as a defendant over the State's willingness to proceed in federal court, because the statements used were not "unequivocally expressed" to satisfy the standard in *Pennhurst*, 465 U.S. at 99. *Clallam Cty.* 849 F.2d at 427.

[7] Plaintiffs seek no monetary award, and so, under *Ex Parte Young*, 209 U.S. 123 (1908), the suit is properly brought against Irene M. Ibarra.

B. 42 U.S.C. § 1396 and Federally Enforceable Rights

Appellee maintans that Colorado hospitals have no statutory right to *any* Medicaid rate since 42 U.S.C. § 1396a(a) (13) (A) is not the kind of statute that creates enforceable rights under 42 U.S.C. § 1983. While readily admitting that in *Colorado Health Care* this circuit held that 42 U.S.C. § 1396 creates enforceable rights under 42 U.S.C. § 1983, appellee asks us to revisit the issue in light of the Supreme Court analysis in *Middlesex Cty. Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1 (1981), and *Pennhurst State School and Hosp. v. Halderman*, 451 U.S. 1 (1981).

In *Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653, 656-58 (4th Cir. 1989), the Fourth Circuit, *en banc*, has viewed precisely this issue and applied precisely the analysis proposed by appellee. We are in complete accord with the Fourth Circuit's reasoning and determination that 42 U.S.C. § 1396a(a) (13) (A) implies a private right of action under § 1983. *Id.* at 656-60. Therefore, we reaffirm our previous holding that § 1396a(a) (13) (A) creates enforceable rights to health care providers under 42 U.S.C. § 1983, and adopt the reasoning of the Fourth Circuit as set forth in *Virginia Hosp. Ass'n*.

C. STANDING

It is axiomatic that only a party with a legally cognizable interest in a case or controversy has standing to obtain judicial resolution in federal court. To some extent "standing" is derived from the "case or controversy" requirement of Article III, § 2. *Warth v. Seldin*, 422 U.S. 490, 498 (1975). If a party does not have standing, i.e.,

does not have a legally cognizable interest in the outcome of the case, no live controversy exists – any issuing federal opinion would be purely advisory, and, as such, prohibited by Article III, Section 2 of the United States Constitution.

Appellee contends that the hospitals, as Medicaid providers, do not have standing to challenge Colorado's Medicaid plan. She asserts that hospitals are not the intended beneficiaries of 42 U.S.C. § 1396, i.e., only Medicaid *patients* have standing to challenge Colorado's Medicaid plan. This issue was squarely presented in *Colorado Health Care Ass'n v. Colorado Dept. of Social Servs.*, 842 F.2d 1158, 1164, n.5 (10th Cir. 1988). Based on the Medicaid patients' and Medicaid providers' "parallel interests with respect to Medicaid funding and reimbursement," this circuit held that Medicaid providers had standing to challenge the state Medicaid plan. *Id.* (citing *Edgewater Nursing Center v. Miller*, 678 F.2d 716 (7th Cir. 1982); *Minnesota Ass'n of Health Care Facilities v. Minnesota Dept. of Pub. Welfare*, 602 F.2d 150 (8th Cir. 1979); *California Hosp. Ass'n v. Obledo*, 602 F.2d 1357 (9th Cir. 1979); *Massachusetts Gen. Hosp. v. Weiner*, 569 F.2d 1156 (1st Cir. 1978); *National Union of Hosp. and Health Care Emp., RWDSU, AFL-CIO v. Carey*, 557 F.2d 278 (2d Cir. 1977)). With no arguments to support the request, appellee has asked us to revisit the issue, and so we have. We find no reason to overrule our original decision in *Colorado Health Care*.[8] Medicaid providers have standing to challenge a state Medicaid plan.

---

[8] It should be noted that a panel decision can only be overruled by the decision of this court sitting *en banc*.

III.

FEDERAL MEDICAID LAW

Title XIX of the Social Security Act, 42 U.S.C. § 1396 (1983), the Medicaid law, authorizes federal grants to States for medical assistance to low-income persons who are aged, blind, disabled, or members of families with dependent children. The program is financed by both the federal and state governments. State participation in the federal Medicaid program is purely voluntary; however, once a State chooses to participate, it must comply with the federal Medicaid laws and regulations. *Harris v. McRae*, 448 U.S. 297, 301 (1980); *Colorado Health Care Ass'n v. Colorado Dept. of Social Servs.*, 842 F.2d 1158, 1164 (10th Cir. 1988).

Under the Medicaid law, each State is required to submit its Medicaid plan to the federal government, specifically the Health Care Financing Administration (HCFA). 42 U.S.C.A. § 1396.[9] The State plan must satisfy the requirements of 42 U.S.C. § 1396a (a) (13) (A) and the relevant federal regulations with respect to the setting of Medicaid payment rates. 42 C.F.R. § 447.200 (1987). Change in payment rates under the State plan requires the State Medicaid Agency to submit the plan amendment to HCFA for approval. 45 C.F.R. § 205.5 (1988). HCFA's review of the proposed State Plan is cursory at best. In essence, its review is limited to whether the "documentation submitted by the State Medicaid Agency complies with procedural requirements."

---

[9] HCFA is the agency within the federal Department of Health and Human Services designated by Congress to administer the Medicaid program at the federal government level.

Under 42 U.S.C. § 1396a(a) (13) (A), a state plan must, *inter alia*, provide for hospital services through the use of rates that the state "finds," and makes "assurances" satisfactory to HCFA:

> [A]re reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality.

Id. In addition, the state plan must "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs." *Id.*

The State need not *submit* the "findings" required by § 1396a (a) (13) (A); it need only *submit* "assurances" that based on its "findings" all requirements of § 1396a (a) (13) (A) have been met. Therefore, HCFA approval is based on state "assurances" of the state's "findings" that the state Medicaid plan is in compliance with federal Medicaid laws and regulations.

Aside from the requirements of § 1396a(a) (13) (A), HCFA has implemented regulations which require state Medicaid agencies to establish payment rates consistent with, *inter alia*, the federal efficiency and economy requirement. 42 C.F.R. §§ 447.250 *et seq.* (1987). These regulations also require that the state Medicaid agencies *make* "findings" and *submit* "assurances" to HCFA that the State plan conforms with Federal laws and regulations. 42 C.F.R. § 447.250(a) (1987). Whenever the State

Medicaid Agency makes a change in its payment methods and standards, it must make "findings" and submit "assurances" to HCFA for approval. 42 C.F.R. § 447.253(a), (b) and (c) (1987). In the event of a change in payment rates, *but not less than annually*, the state agency must, *inter alia*, make the following findings:

> (1) *Payment Rates*. The state agency's payment rates are "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards." (42 C.F.R. § 447.253(b) (1).)
>
> (2) The payment rates must "take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs." (42 C.F.R. § 447.253(ii) (A).)
>
> (3) "The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality." (42 C.F.R. § 447.253(ii) (C).)

IV.

Federal Court Review of State Medicaid Plan

The Hospitals contend that the district court, misreading this court's decision in *Colorado Health Care Ass'n v. Colorado Dept. of Social Servs.*, 842 F.2d 1158, 1164 (10th Cir. 1988), improperly limited its review of the Colorado Medicaid plan by determining only "whether the findings of the State Medicaid Agency were arbitrary and capricious." We agree.

In passing on the validity of a state Medicaid plan under federal law, the court must determine whether the plan is procedurally and substantively in compliance with the requirements of the Federal Medicaid Act and its implementing regulations, and not limit its analysis to whether the nonadjudicatory agency findings are arbitrary and capricious. In *Colorado Health Care*, presented with a challenge to the validity of the change in the Colorado Medicaid payment rates, this circuit held that *"[i]f the appellees have met the specific requirements of federal* and state *law*, then we must defer to the agency's exercise of discretion unless the DSS acted arbitrarily or capriciously." *Id.* at 1165 (emphasis added) (citing *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416 (1971); *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 516 (5th Cir. 1983); *Mary Washington Hosp. v. Fisher*, 635 F.Supp. 891, 897 (E.D. Va. 1985)).[10] Quoting from *Colorado Health Care*, "Our *first* inquiry is whether the payment to the appellants . . . resulted in noncompliance with the federal statute and regulations." *Id.* (emphasis added.) This is an issue of law, subject to *de novo* review in federal court. The state agency's determination of procedural and substantive compliance with federal law is not entitled to the deference afforded a federal agency. *Turner v. Perales*, 869 F.2d 140, 141-42 (2d Cir. 1989) (distinguishing *Chevron U.S.A. v. Natural Resources Defense Council*, 467 U.S. 837, 843-44 (1984), in which the Supreme Court held that the *federal* agency set up to implement the *federal* law was

---

[10] In addition, we cite *West Virginia University Hospitals v. Casey*, 701 F.Supp. 496, 512 (M.D. Pa. 1988); *Thomas v. Johnston*, 557 F.Supp. 879, 901 (W.D. Tex. 1983).

entitled to deference so long as its interpretation was not arbitrary or capricious or manifestly contrary to law.) Indeed, the district court improperly limited its review as to whether the Colorado Medicaid Agency's findings and assurances were arbitrary and capricious to determine whether the state plan violated federal law.

V.

COLORADO MEDICAID PLAN'S COMPLIANCE WITH PROCEDURAL REQUIREMENTS OF FEDERAL LAW AND REGULATIONS

To assure state compliance, the Federal Medicaid Act and implementing regulations require two separate procedures to be performed annually or any time a new state Medicaid plan is instituted: First, the State Medicaid Agency must engage in a "finding" process that all federal requirements have been met to substantiate its assurances, including the assurances that its payment rates satisfy the "efficiency and economy" requirement. Second, the State Medicaid Agency must supply HCFA with "assurances" that all federal requirements have been met, including the "efficiency and economy" requirement. 42 U.S.C. § 1396a(a) (13) (A); 42 C.F.R. § 447.205; 42 C.F.R. § 447.250(a); 42 C.F.R. § 447.253(a) and (b).

The plain language of federal Medicaid law mandates the State Medicaid Agency, *at a minimum*, to make "findings" which identify and determine (1) efficiently and economically operated hospitals; (2) the costs that must be incurred by such hospitals; and, (3) payment rates which are reasonable and adequate to meet the reasonable costs of the state's efficiently and economically operated hospitals. Appellee argues that federal law

does not mandate these findings. We disagree with appellee's construction of federal law. The courts are the final authorities on issues of statutory construction and "must reject administrative constructions of the statute . . . that are inconsistent with the statutory mandate." *Federal Election Comm'n v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 32 (1981). We reject appellee's construction of the requirements of the federal Medicaid Act and its implementing regulations and hold that the federal Medicaid Act mandates the above enumerated findings.

Appellee's evidence at trial is flagrantly devoid of any effort to make the federally required findings. David West, the Director of the Division of Programs for the Colorado Medicare (sic) Program, readily admitted the State did not determine which hospitals are efficiently and economically run, and made no efforts to do so. In addition, he readily admitted the State did not determine the costs that must be incurred by the efficiently and economically operated hospitals. However, on appeal, appellee illogically insists that the State found and assured HCFA that its hospital rates are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in compliance with 42 U.S.C. 1396a (a) (13) (A) and 42 C.F.R. § 447.253(a) and (b). Furthermore, appellee argues that since the federal government does not prescribe the steps to be taken in making the required findings, the State can simply comply with the federal requirements by assuring HCFA that it found its new plan to be in compliance with federal law.

The evidence at trial was that the bases for the State Medicaid Agency's so-called findings were the consistency between the current expenditure for Medicaid provider reimbursement and the amount of money historically appropriated by the Colorado legislature, and HCFA's acceptance of the previous Colorado Medicaid Plan submitted prior to 1980. We hold that neither bases or the combination of the two identify and determine: (1) the efficiently and economically operated hospitals; (2) the costs that must be incurred by such hospitals; and, (3) the payment rates which are reasonable and adequate to meet the reasonable costs that must be incurred by the efficiently and economically operated hospitals. The State's reliance on the HCFA's acceptance of a ten year old Medicaid plan is misplaced. The federal requirement is that the findings discussed *supra* be done annually or in the event of the implementation of a new plan. 42 U.S.C. § 1396a (a) (13) (A) and 42 C.F.R. 447.253(b) *et seq*. Furthermore, nowhere in the federal Medicaid Act or the implementing regulations does it even imply that a state may rely solely on a previously accepted state Medicaid plan or the fact that the monetary appropriations under the old plan are the same as under the new plan. In fact, reliance on HCFA's approval of a previous plan is completely undercut by the requirement that the state make *annual* findings or even more frequently in the event of implementation of a new plan.

While it is true that a state is free to create its own method for arriving at the required findings, this does not absolve the state from making the required findings. Appellee's argument confuses this. Mere recitation of the

wording of the federal statute is not sufficient for procedural compliance. There is a presumption that a state will engage in a bona fide finding process before it makes assurances to HCFA that the required findings have been made. To rule otherwise would completely eviscerate the federal requirements so long as the magic words are submitted to HCFA.

Based on our analysis of the governing federal law and the evidence at trial, we hold that appellee did not comply with the procedural requirements of 42 U.S.C. § 1396a(a) (13) (A). As such, we hold the Colorado Medicaid Plan, effective July 1, 1988, to be violative of the procedural requirements of the controlling federal law.

VI.

PAYMENT RATES UNDER NEW DRG PLAN VIOLATE THE "EFFICIENCY AND ECONOMY REQUIREMENT" OF FEDERAL LAW

As discussed earlier in this opinion, under Colorado's new DRG plan, payment rates to Medicaid providers are calculated by the application of a .88 reduction factor to average *Medicare* costs[11] given the same DRG, as determined by cost standards in 42 U.S.C. § 1395x(v) (1) (A) (1983) and 42 C.F.R. § 413.1 *et seq.* (1987). Then the budget adjustment factor (BAF), .54, is multiplied by the already reduced payment rate, thus cutting provider reimbursement 46% across the board.

---

[11] Medicare reimbursement does not cover all actual hospital costs. It compensates only *allowable* costs which are *reasonable*.

Appellants do not challenge the DRG system of reimbursement or the application of the .88 reduction factor. They challenge the *actual* payment rates produced under the new DRG system because the base rates used to calculate DRG payments have been drastically reduced by the application of the BAF, a factor based solely on budget constraints. More importantly, they maintain that the application of the BAF is violative of 42 U.S.C. § 1396a(a) (13) (A) and its implementing regulations since under the new plan, no Colorado hospital, no matter how efficiently and economically operated, will be reasonably and adequately compensated to meet the costs which must be incurred.

Based on uncontradicted evidence at trial, the district court found that no Colorado hospital will receive *actual* reimbursement for its costs as a result of the application of the BAF to the base rates. In addition, the district court found that some Colorado hospitals are efficiently and economically operated. Appellants contend that these two findings compel the conclusion that the Colorado Medicaid Plan violates the substantive requirements of the federal Medicaid Act. We hesitate to take the logical leap which appellants urge since federal Medicaid law does not require *actual* reimbursement. However, after review of the evidence at trial and controlling federal law, we agree that the Colorado Medicaid Plan violates the substantive provisions of Federal Medicaid law, but for the reasons set out below.

Kathleen Means, appellants' expert witness, testified at trial as an independent consultant in health care financing. She was qualified as an expert based on sixteen years of employment with the federal Medicare program

and two years at Blue Cross/Blue Shield as National Director of Provider Payment System. She previously testified in two federal trials on behalf of HCFA regarding the same statutes and regulations in question here. She spent two years as a member of the federal task force that designed the Medicare DRG system. She co-authored the federal Medicaid regulations pertaining to Medicaid payment rates for inpatient hospital services. Her specific responsibility at HCFA was to review state Medicaid agencies' plans for reimbursing hospital services.

At trial, Ms. Means testified that under the new Colorado Medicaid Plan, *no* Colorado hospital, no matter how efficiently and economically operated, would be adequately and reasonably reimbursed for inpatient hospital services. The basis for her opinion was the requirements of federal Medicaid law and her familiarity with the methodologies used by other states in computing reimbursement rates using peer groupings as used by the Colorado plan, and her familiarity with the Colorado Medicaid Plan in question. She testified that for each peer group, hospitals are usually ranked from lowest to highest cost. Then the state chooses a certain percentile of the peer group and each hospital at or below the chosen percentile will have its costs met. Those hospitals at or below the percentile cut-off are designated the efficiently and economically operated hospitals. In other words, if a state chooses the sixtieth percentile, sixty percent of the hospitals will be reimbursed for the expenses they have incurred. If a hospital's expenses are above the sixtieth percentile, they will only be reimbursed for the costs incurred by a hospital at the sixtieth percentile. If a hospital is below the sixtieth percentile, that hospital may

even be reimbursed above its actual costs. So, the hospital at the sixtieth percentile more or less sets the payment rate for that peer group. An alternate method used to set reimbursement rates is the average cost per discharge diagnosis of all the hospitals in the peer group. In effect, this is the system which Colorado uses *prior* to the application of the budget adjustment factor, .54, resulting in reimbursement of only 54% of the average cost. Due to the effect of this BAF, provider reimbursement has been brought down to the zero percentile for each peer group. Therefore, no Colorado hospital, no matter how efficiently and economically operated, is reasonably and adequately reimbursed for costs which must be incurred in violation of 42 U.S.C. § 1396a(a) (13) (A). In comparing the zero percentile of reimbursement with percentiles of other states, Ms. Means testified that the lowest percentile she had ever seen was the fiftieth percentile. Furthermore, she testified that in one third of the states, the states pay the peer group averages; in the other third, states pay statewide averages; and in the final third, states pay facilities specific DRG rates. Ms. Means' testimony went unrebutted at trial.

In addition to Ms. Means, Mr. Hart, Vice-President for Fiscal Services of the Colorado Hospital Association,[12] testified that no hospital in Colorado would be reimbursed its reasonable costs under the new system. Mr.

---

[12] Specifically, Mr. Hart was responsible for the financial issues dealing with hospital reimbursement issues for the Colorado Medicare program, Medicaid program. There are one hundred Colorado hospitals in the Colorado Hospital Association.

Hart was a member of the DRG Advisory Task Force which was formulated to provide recommendations to the Colorado Department of Social Services, the state agency responsible for Colorado's Medicaid program.

David West, the Director of the Division of Programs for the Colorado Medicaid Program, admitted at trial that he had no data that shows that the actual payment rates being made to Colorado hospitals under the new DRG system will reimburse any Medicaid providers reasonable costs. However, he testified that the proper findings and assurances were made and the new state plan complied with federal law. His assurances at trial and to HCFA rested solely on the historical trends concept, i.e., since the old system was adequate, and the same amount of dollars are paid out under the new system, the new system must be adequate. The problem with his reasoning is twofold: first, the state Medicaid Agency must make the required findings annually or in the event of the implementation of a new plan; and, second, the findings upon which the new plan is based were made prior to the enactment of the Omnibus Budget Reconciliation Act of 1981, which mandated a state payment rate to be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated providers. *See, e.g., Colorado Health Care Ass'n v. Colorado Dept. of Social Servs.*, 842 F.2d 1158, 1165-66; *Illinois Hospital Ass'n v. Illinois Dept. of Public Aid*, 576 F.Supp. 360, 362 (N.D. Ill. 1983).

Aside from the expert testimony at trial, we independently conclude that based on the application of the BAF, resulting in a 46% reduction of the Medicaid reasonable cost as calculated by the 88% reduction of the Medicare

reasonable cost, no Colorado hospital is reasonably or adequately compensated. The reasonable Medicaid cost would be .88 x reasonable Medicare cost, given the same DRG. Under Colorado's new plan, all hospitals are reimbursed only about half their reasonable costs. In addition, we agree with the district court's finding that some Colorado hospitals are efficiently and economically operated; therefore, pursuant to § 1396a (a) (13) (A), those hospitals must be compensated for their reasonable costs for the plan to comply with federal Medicaid law.

After a careful review of the record, we find that appellee offered no credible evidence to support the "finding" that the new Medicaid reimbursement rates comply with federal law. Now on appeal, appellee baldly "assures" us that the State Medicaid plan complies with federal law. Perhaps "assurances" are adequate for HCFA, but at trial a party must offer evidence, which supports its position. Since we find no evidence admitted at trial to support appellee's "assurances" on appeal, and find overwhelming evidence to the contrary, we hold that the Colorado Medicaid Plan, effective July 1, 1988, is violative of the substantive provisions of federal Medicaid law. Specifically, we hold that the application of the BAF resulting in an across the board 46% reduction such that no Colorado hospital, no matter how efficiently and economically operated, is reasonably and adequately reimbursed violates 42 U.S.C. § 1396a(a) (13) (A) and its implementing regulations. Therefore, we prohibit the use of this BAF. However, in so doing, we do not prohibit the use of any BAF in the future. This court is mindful of state budgetary constraints and would approve of the

application of a BAF so long as the resulting reimbursement rates complied with controlling federal law.

VII.

FINDINGS AND ASSURANCES – ARBITRARY AND CAPRICIOUS

Appellants allege that the payment rates produced under the new DRG system are arbitrary and capricious as a result of the application of the budget adjustment factor. The district court found that:

> The fact that the State Medicaid Agency adjusted repayment rates according to State budgetary constraints does not invalidate the agency's findings. In *Colorado Health*, the Tenth Circuit Court of Appeals construed the same provision of law at issue here, 42 U.S.C. § 1396a(a) (13) (A). *Id.* at 1165. The court held that states can consider budgetary constraints *as a factor* in amending medicaid payment methods. *Id.* at 1168. Similarly, the State Medicaid Agency is entitled to rely on budgetary considerations in setting repayment rates.

(emphasis added.) We agree with the district court's conclusions, but nevertheless hold that the State Medicaid Agency's findings and assurances that the new Colorado Medicaid plan complies with federal law were arbitrary and capricious.

In reviewing nonadjudicatory agency actions, the court must determine whether the agency action was based upon "a consideration of the relevant factors and whether there has been a clear error of judgment." *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416 (1971). "The standard of review is highly deferential,

presuming the agency action to be valid . . . *if a reasonable basis exists* for its decision." *California Hosp. Ass'n v. Schweiker*, 559 F.Supp. 110, 116 (1982) (emphasis added). However, the court is still obliged "to engaged in a substantial inquiry." *Overton Park*, 401 U.S. at 415. In other words, the presumption of validity "is not to shield [the agency's] action from a thorough, probing, in-depth review." *Id.* In essence, our task is to determine if there was a reasonable factual basis to support the State Medical Agency's findings and assurances that, under Colorado's new Medicaid plan, the efficiently and economically operated hospitals are reasonably and adequately reimbursed for the costs which must be incurred as mandated by 42 U.S.C. § 1396a(a) (13) (A).

While *Colorado Health* does declare that the State Medicaid Agency may consider budgetary constraints, budgetary constraints cannot excuse noncompliance with federal Medicaid law. *Wisconsin Hosp. Ass'n v. Reivitz*, 733 F.2d 1226, 1236 (7th Cir. 1984); *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 518, 521; *Illinois Hosp. Ass'n v. Illinois Dept. of Public Aid*, 576 F. Supp. 360, 368 (1983) (citing *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 396 (5th Cir. 1980)). While *Colorado Health* allows the state to consider budgetary factors *as a factor* in amending Medicaid payments, consideration of budgetary factors alone does not translate to automatic compliance with the federally mandated findings that efficiently and economically operated hospitals are reasonably and adequately compensated for the costs which must be incurred. 42 U.S.C. § 1396a(a) (13) (A); 42 C.F.R. 447.200(a); 42 C.F.R.

§ 447.253(a) and (b).[13] A "state must articulate 'a rational connection between the facts found and the choice made.' " *Colorado Health*, 842 F.2d at 1167, citing *Baltimore Gas & Elect. v. Natural Resources Defense Council*, 462 U.S. 87, 105 (1983).

In *Colorado Health*, we upheld the elimination of the incentive or bonus-type payments to providers because the State Medicaid Agency made the proper findings that the amended plan was in compliance with controlling federal law, i.e., there was a reasonable basis for the Agency's findings. *Id.* at 1169. The Colorado Medicaid Agency had "considered some forty (40) different options for cutting the program costs." *Id.* at 1167. In addition, we found that the Agency considered "the relevant factors and data so that a ration relationship exist[ed] between" the facts considered and the resulting findings. *Id.* We also specifically found that the factors relevant to the "efficiency and economy standard" were considered before the Agency's findings of compliance with federal Medicaid law. *Id.*

The record in this case is blatantly devoid of any effort by the Colorado Medicaid Agency to make the

---

[13] Quoting from the Finance Committee Recommendations as to 42 U.S.C. § 1396 *et seq.*: "The Committee continues to believe that States should have flexibility in developing methods of payment for their medicaid programs . . . . The flexibility given the States is not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care." S. Rep. No. 139, 97th Cong., 2d Sess., *reprinted in* 1981 U.S. Code Cong. & Admin. News 744.

federally mandated findings. Based *solely* on budgetary constraints, CDSS assured HCFA that the proper findings of federal compliance were made. We hold that there was no reasonable basis for its "findings" or its assurances to HCFA. While budgetary constraints may be a factor to be considered by a state when amending a current plan, implementing a new plan, or making the annually mandated findings, budgetary constraints alone can never be sufficient. *Illinois Hosp. Ass'n*, 576 F.Supp. at 368. "If a state could evade the requirements of the [Medicaid] Act simply by failing to appropriate sufficient funds to meet them, it could rewrite the congressionally imposed standards at will." *Alabama Nursing Home Ass'n v. Califano*, 433 F.Supp. 1325, 1330 (M.D. Ala. 1977), *rev'd and vacated in part on other grounds, sub nom.*, 617 F.2d 388 (5th Cir. 1980).

Appellee argues that budgetary constraints were not the sole factor considered when making the required findings and assurances; in fact, appellee relied on the prior approval of a ten year old plan. This was not a reasonable basis for the findings. Federal law mandates *annual* findings.

Therefore, we hold Colorado Medicaid Agency's factual foundation and subsequent findings and assurances are not reasonably related. The evidence before us reveals arbitrary and capricious actions. Accordingly, we REVERSE the district court on this issue.

CONCLUSION

In sum, we declare the new Colorado Medicaid Plan, effective July 1, 1988, violative of the procedural and

substantive requirements of the Federal Medicaid Act and its implementing regulations. In addition, we REVERSE the district court and hold that the findings made and assurances submitted to HCFA lacked any reasonable basis, and, as such, were arbitrary and capricious. Specifically, we hold that the application of the Budget Adjustment Factor, .54, resulting in an across the board 46% reduction in provider reimbursement, violates controlling federal Medicaid law under these facts, and prohibit its usage as of the date of this opinion. However, is so doing, we do not foreclose future application of a BAF so long as the resulting provider rates comply with federal law.

We remand to the district court to order defendant, Irene M. Ibarra, Executive Director of the Colorado Department of Social Services, to comply with the procedural and substantive requirements of the federal Medicaid Act and its implementing regulations, and to engage in a *bona fide* finding process before submitting any new plan and/or assurances to HCFA.

REVERSED AND REMANDED.

No. 89-682

In The

Supreme Court of the United States

October Term, 1989

THE STATE OF COLORADO DEPARTMENT OF SOCIAL SERVICES, and IRENE M. IBARRA, Executive Director of the State of Colorado Department of Social Services,

Petitioners,

v.

AMISUB (PSL), d/b/a/ AMI St. Luke's Hospital, Inc., AMI Presbyterian Denver Hospital, Inc., and AMI Presbyterian Aurora Hospital, Inc.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

PATRIC HOOPER
HOOPER, LUNDY & BOOKMAN, INC.
Fox Plaza, Suite 430
2121 Avenue of the Stars
Los Angeles, CA 90067-5010
(213) 551-8165

Attorneys for Respondents

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTION PRESENTED

Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. Section 1983 to enforce the Medicaid Act against a state.

RULE 29.1

Pursuant to the requirements of Rule 29.1 of the United States Supreme Court, the affiliates of AMISUB (PSL) and the hospitals pursuant to which AMISUB (PSL) does business are the subsidiaries of American Medical International, Inc., the parent company of AMISUB (PSL). During all times relevant herein, American Medical International, Inc., was a publicly-owned health care company. It is now privately owned by IMA. Holdings Corp., an investment partnership formed by Harry Gray, Mel Klein, and Partners LP and First Boston Investments, Inc.

TABLE OF CONTENTS

TABLE OF AUTHORITIES – Continued

No. 89-682

In The

Supreme Court of the United States

October Term, 1989

THE STATE OF COLORADO DEPARTMENT OF SOCIAL SERVICES, and IRENE M. IBARRA, Executive Director of the State of Colorado Department of Social Services,

Petitioners,

v.

AMISUB (PSL), d/b/a/ AMI St. Luke's Hospital, Inc., AMI Presbyterian Denver Hospital, Inc., and AMI Presbyterian Aurora Hospital, Inc.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

Pursuant to the request of the Court, as communicated by the Court Clerk in his December 20, 1989 letter to counsel, respondents AMISUB (PSL) d/b/a AMI St. Luke's Hospital, Inc., AMI Presbyterian Denver Hospital, Inc. and AMI Presbyterian Aurora Hospital, Inc. ("Hospitals"), appellants below, file this Response to the Petition for Writ of Certiorari.

As the sole ground for their petition, the State of Colorado Department of Social Services, and Irene M. Ibarra, Executive Director of the State of Colorado Department of Social Services (the "Colorado Medicaid Agency") raises the issue of whether a Medicaid provider has a private federal cause of action under 42 U.S.C. Section 1983 to enforce the Medicaid Act against a state. This is the very same issue on which certiorari was granted in *Gerald L. Baliles, et al. v. Virginia Hospital Association*, No. 88-2043, argued January 9, 1990.

Because the Court granted certiorari in *Baliles* and because that case has been fully argued on the merits, this response to the instant Petition for Certiorari will be limited to emphasizing certain critical facts and assertions applicable to this case.

OPINIONS BELOW

The opinion of the United States District Court for the District of Colorado is not reported and is set forth in the Appendix to the Petition for Certiorari at Appendix 1. The opinion of the United States Court of Appeals for the Tenth Circuit is reported at 879 F.2d 789 and is set forth in the Appendix to the Petition for Certiorari at Appendix 11.

JURISDICTION

The jurisdiction of this Court is invoked under 28 U.S.C. Section 1254(1) (1982). The decision of the Court of

Appeals was rendered on July 11, 1989, and a petition for rehearing with suggestion for rehearing en banc was denied August 31, 1989.

STATUTORY PROVISION INVOLVED

The applicable statutory language is contained in the Petition at page 1.

STATEMENT OF THE CASE

The Hospitals adopt by reference the statement of the case contained in the opinion of the United States Court of Appeals for the Tenth Circuit set forth in the Appendix to the Petition at 12-16.

ARGUMENT

If the Court decides unequivocally in *Baliles* that Medicaid providers have a private federal cause of action under 42 U.S.C. Section 1983 to enforce the Medicaid Act against a state, the Colorado Medicaid Agency's Petition for Certiorari will have to be denied. However, if the Court's opinion is limited in some manner to the facts of the *Baliles* case, the following facts of the instant case are critical and compel a denial of the Colorado Medicaid Agency's Petition without regard to the outcome in *Baliles*.

First, the Hospitals were expressly precluded from administratively challenging the use of the budget adjustment factor ("BAF"), the factor which caused the Medicaid payment rates in question to violate federal Medicaid law. *See* Joint Pretrial Order, Stipulated Facts, para. 11, Appendix at 10. Thus, the regulatory provision, 42 C.F.R. Section 447.253(c) [1987], requiring states to provide appeals or exception procedures for individual providers was meaningless because the State Medicaid Agency precluded any challenge to the BAF, the fatal flaw in Colorado's Medicaid payment system.

Second, as a result of the lack of a viable administrative appeal process to challenge the BAF, the Hospitals sought prospective relief in federal court to enjoin the use and application of the BAF. The suit was initiated and temporary relief was sought prior to the effective date of the new payment rates, July 1, 1988. No eleventh amendment concerns were thus engendered since no type of retroactive relief or relief in the form of money damages was sought against individual state officials.

Third, in the trial court, the Colorado Medicaid Agency agreed and stipulated that the federal district court had federal question jurisdiction to resolve the issues presented. Pretrial Order, Jurisdiction, Appendix at 2. The State Medicaid Agency raised no objection to the Hospitals' standing or to their right to maintain a private right of action under 42 U.S.C. Section 1983. Pretrial Order, Claims and Defenses, Appendix at 2-4. Rather, over the objection of the Hospitals, the State Medicaid Agency raised the standing and private right of action issues for the first time on appeal.

Fourth, notwithstanding its assurances to the federal government to the contrary, the Colorado Medicaid Agency did not engage in the finding process required by federal Medicaid law and regulations. The Court of Appeals characterized the State Medicaid Agency's conduct as "flagrantly devoid of any effort to make the federally required findings." Appendix to Petition at 27. For example, the State Medicaid Agency admitted that it made no effort to determine which Colorado hospitals were efficiently and economically run. It also admitted that it did not determine the costs that must be incurred by the efficiently and economically operated hospitals. Appendix to Petition at 27.

Even if, for argument purposes only, Medicaid providers have no private right to obtain court enforcement of any particular *substantive* payment rate, they certainly must have access to a federal court to assure that a state Medicaid agency complies with the *procedures* required by Medicaid law and regulations.

Fifth, although the State Medicaid Agency did *not* engage in the finding process required by the federal Medicaid law and regulations, it nevertheless "assured" the federal government in 1988, that it had made the appropriate findings. *See* Joint Pretrial Order, Stipulated Facts, para. 13, Appendix at 11. Thus, it cannot be presumed that state Medicaid agencies will have actually done what they assure the federal government they have done.

Sixth, due to the extremely limited oversight role of the federal government and its practice of accepting assurances at face value, the federal government took no

action on the July 1988 assurances until *after* the Court of Appeals invalidated the BAF in July 1989. The federal government delayed its action notwithstanding the lack of an actual finding process, and the issuance of the federal district court decision which expressly revealed that the BAF had nothing to do with hospital costs and that no Colorado hospital would receive reimbursement for its costs no matter how efficiently and economically operated. *See* Appendix to Petition at 6-7. Thus, the federal government's "monitoring" is not an adequate safeguard to assure compliance with federal law.[1]

Seventh, although a "zone" of permissible rates might generally serve to satisfy a State Medicaid Agency's obligation under the federal efficiency and economy requirement, judicial review is necessary to assure that the zone is not stretched beyond rationality. This case demonstrates the need for federal court review to assure such rationality. If the appellate court had not intervened, the State Medicaid Agency would have continued to implement payment rates which, due to the BAF, did not reimburse the costs of *any* Colorado hospitals, *even* the most efficiently and economically operated hospitals.[2]

---

[1] If judicial intervention had not occurred, the mere recitation of the "magic words" in the assurances submitted to the federal government would have apparently been sufficient to the federal government thus completely eviscerating the federal requirements. *See* Appendix to Petition at 29.

[2] The United States Court of Appeals for the Tenth Circuit has appropriately recognized its limited role in reviewing the

(Continued on following page)

Eighth, the Court of Appeals appropriately limited the relief required to enjoining the application of the BAF. It did *not* invalidate the entire payment system. It did *not* even rule out the possibility that an appropriately determined BAF could be applied in the future. The Court's opinion simply and correctly served to compel the State Medicaid Agency to adhere to the applicable procedural and substantive requirements of the Medicaid law and regulations in connection with developing changes in Medicaid payment rates.

CONCLUSION

The Court is respectfully requested to consider the above in ruling on the Colorado Medicaid Agency's Petition for Certiorari.

DATED: January 17, 1990.

Respectfully submitted,

PATRIC HOOPER, a Member of
HOOPER, LUNDY, & BOOKMAN, INC.

(Continued from previous page)

substance of state Medicaid payment rates under the Medicaid law and regulations. Indeed, in *Colorado Health Care Ass'n v. Colorado Dept. of Social Services*, 842 F.2d 1158 (10th Cir. 1988), the court upheld certain changes in Medicaid payment rates for long term care services established by the very same state Medicaid agency in question. In the instant case, however, the BAF was so arbitrary that it unquestionably caused the resulting payment rates to violate the applicable federal Medicaid payment criteria.

APPENDIX

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 88-F-1024

AMISUB (PSL), INC., d/b/a AMI ST. LUKE'S HOSPITAL, INC.,
AMI PRESBYTERIAN DENVER HOSPITAL, INC., and
AMI PRESBYTERIAN AURORA HOSPITAL, INC.,

Plaintiffs,

vs.

THE STATE OF COLORADO DEPARTMENT OF SOCIAL SERVICES, and IRENE M. IBARRA, EXECUTIVE DIRECTOR OF THE STATE OF COLORADO, DEPARTMENT OF SOCIAL SERVICES,

Defendants.

JOINT PRETRIAL ORDER

(Filed Aug. 8, 1988)

I. *DATE AND APPEARANCES*

This Pretrial Order is presented for the Court's consideration on August 8, 1988. Plaintiffs (hereinafter "Plaintiff Hospitals") appear by L. Richard Freese, Jr., Esq. and Sharon E. Caulfield, Esq., of Davis, Graham & Stubbs, and by Patric Hooper, Esq., of Hooper, Lundy & Bookman, Inc. Defendants (hereinafter "The State Medicaid Agency") appear by Wade Livingston, First Assistant Attorney General, and Vivianne Oates, Assistant Attorney General, of the Office of the Attorney General, State of Colorado.

II. *JURISDICTION*

This Court has jurisdiction to resolve the federal questions in dispute pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1361, and 42 U.S.C. § 1983.

III. *CLAIMS AND DEFENSES*

A. Plaintiff Hospitals contend:

1. That due to the application of a State budget factor, the Medicaid payment rates for inpatient hospital services produced under 10 C.C.R. 2505-10, Sections 8.356 and 8.351.40 (which went into effect July 1, 1988), are not reasonable or adequate to meet the costs that must be incurred by efficiently and economically operated hospitals in the provision of services in conformity with applicable state and federal laws, regulations, and quality and safety standards. As a result, the application of the budget factor causes the State Medicaid payment rates to violate the requirements of the governing federal Medicaid statute and regulations.

2. That in establishing the final payment rates, the State Medicaid Agency did not analyze, determine or define (a) efficiently and economically operated providers, (b) the costs that must be incurred by such providers, or (c) a rate adequate to meet such costs.

3. That the final payment rates resulting from the application of the budget adjustment factor are arbitrary and capricious because (a) the budget adjustment factor requires the Medicaid agency to ignore various factors relevant to the determination of the costs that

must be incurred by efficiently and economically operated providers, and (b) the payment rates fail to distinguish between those providers which are efficiently and economically operated and those which are not.

4. That by limiting the final payment rates for inpatient hospital services by the legislatively mandated budget factor, the Colorado State Legislature has caused the State Medicaid Agency to violate the single state agency requirements of the applicable Medicaid statute and regulations since the State Medicaid Agency is deprived of the discretion necessary to determine final payment rates.

5. That the Court has jurisdiction to award the relief requested by Plaintiff Hospitals.

B. The State Medicaid Agency contends:

1. That the final payment rates do not represent a cut or reduction in expenditures for hospital services under the Medicaid program. Historically, these expenditure levels have been sufficient to enlist enough providers so that hospital services were available to Medicaid recipients at least to the extent that those services are available to the general public. Further, these historical expenditure levels were made under a state plan approved by the Secretary of the United States Department of Health and Human Services. Accordingly, the Department contends that its determination that the rates are reasonable and adequate to meet the costs of efficiently and economically operated facilities is not arbitrary and capricious.

2. That the State Medicaid Agency has made all necessary findings and assurances required by Federal law.

3. That, under the doctrine of primary jurisdiction, the Court should defer ruling in this case until the Federal Health Care Financing Administration ("HCFA") has completed its review of the new system for determining payment rates.

4. That the State Medicaid agency meets all Federal requirements of a single state agency.

5. That the Court is without jurisdiction to grant the relief sought by Plaintiff Hospitals under the Eleventh Amendment to the United States Constitution.

IV. *STIPULATIONS*

A. *Glossary of Terms.*

Plaintiff Hospitals and the State Medicaid Agency agree that the following terms shall have the following meanings for purposes of this case:

1. *Provider.* An institution that furnishes inpatient hospital services.

2. *State Medicaid Agency.* The single State agency within a State government established or designated to administer or supervise the administration of the State's Medicaid plan. In Colorado, the State of Colorado Department of Social Services is the single State agency.

3. *Health Care Financing Administration, or HCFA.* The agency within the federal Department of Health and Human Services designated by Congress to

administer the Medicaid program at the federal government level.

4. *State Plan*. A comprehensive document which is required to be established and maintained by the State Medicaid Agency and governs the administration of the State's Medicaid program.

5. *The Federal Requirement*. The requirement stated in 42 U.S.C. § 1396a(a)(13)(A) that the State Plan must provide for payment for inpatient hospital services " . . . through the use of rates . . . which the state finds, and makes assurances satisfactory to the secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality control standards. . . ."

6. *Actual Costs*. The total capital and operating costs incurred by a provider in furnishing services to its patients.

7. *Allowable Costs*. Those categories of direct and indirect capital and operating costs which are reimbursable under the Medicare "reasonable cost" standards of 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.1 *et seq*. Not all Actual Costs are Allowable Costs under the Medicare standards.

8. *Reasonable Costs*. That portion of Allowable Costs determined to be reasonable in amount under the Medicare reasonable cost standards.

9. *DRGs*. Diagnosis-related groups, consisting of approximately 475 clinically cohesive groupings of

inpatient hospitalizations which consume similar amounts of resources. A DRG classification generally describes a clinical category of disease.

10. *Relative Weights*. The relative weight assigned to each DRG which reflects relative resource consumption. For example, a Relative Weight of 1.00 represents a measure of the average resource consumption for the entire group of DRGs.

11. *Base Rate*. The standard payment rate to be applied under a DRG payment system, as defined in 10 C.C.R. 2505-10, section 8.356.20, paragraph 3.

12. *Routine Services*. Essentially room and board services furnished by Providers to patients.

13. *Ancillary Services*. Those hospital services for which a charge separate from the room and board charge is ordinarily made by a Provider. Examples of ancillary services include laboratory tests, x-rays, and pharmacy services.

14. *Exempt Services*. Those routine and ancillary services furnished by Providers in parts of general acute care hospitals (known as "distinct units") which are not covered by the DRG payment rates.

B. *Stipulated Facts*.

1. Plaintiff Hospitals are duly licensed by the State of Colorado to provide acute care hospital services. Plaintiff Hospitals also participate in the Colorado Medicaid program as Providers of inpatient hospital services. Plaintiff Hospitals function as tertiary care centers for the Denver area.

2. Defendant Irene M. Ibarra is the Executive Director of the State of Colorado Department of Social Services, the single State agency designated by the federal government to administer the Medicaid program in Colorado.

3. Title XIX of the Social Security Act, 42 U.S.C. Sections 1396 *et seq.*, the Medicaid law, authorizes federal grants to States for medical assistance to low-income persons who are aged, blind, disabled, or members of families with dependent children. The program is jointly financed by the federal and state governments and administered by the States. The States, in accordance with federal law, decide eligible beneficiary groups, types and ranges of services, payment level for services, and administrative and operative procedures. Payment for services are made directly by States to the individuals or entities that furnish the services. 42 C.F.R. § 430.0.

4. Under the Medicaid statute, each State is required to submit for HCFA approval a State Plan for the provision of medical assistance to eligible beneficiaries. 42 U.S.C. § 1396. The State Plan must comply with the requirements of 42 U.S.C. § 1396a and the applicable federal regulations with respect to the setting of Medicaid payment rates. 42 C.F.R. § 447.200. Modification of the methods and standards by which payment rates are determined requires a State Medicaid Agency to submit a State Plan Amendment which must be approved by HFCA [sic]. 45 C.F.R. § 205.5.

5. Under 42 U.S.C. § 1396a(a)(13)(A), a State Plan must, *inter alia*, provide for payment for hospital services through the use of rates which the State finds,

and makes assurances satisfactory to HCFA are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in the provision of services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. This is the Federal Requirement. See Glossary, p. 5.

6. HCFA has issued implementing regulations which require State Medicaid Agencies to establish payment rates consistent with, *inter alia*, the Federal Requirement. 42 C.F.R. §§ 447.250 *et seq*. The regulations also require that State Medicaid Agencies make "findings" and submit "assurances" based on such findings that the statutory requirements, including the Federal Requirement, are satisfied.

7. For hospital admissions occurring on or after July 1, 1988, the State Medicaid Agency has implemented a DRG-type system for reimbursing Colorado hospitals for providing inpatient hospital services to Medicaid beneficiaries. 10 C.C.R. 2505-10, Section 8.356. DRGs are diagnosis-related groups, consisting of approximately 475 clinically cohesive groupings of inpatient hospitalizations, which consume similar amounts of resources. A DRG classification generally describes a clinical category of disease. A relative weight is assigned to each category of disease which reflects relative resource consumption. For example, a relative weight of 1.00 represents a measure of the average resource consumption for the entire group of DRGs. Under 10 C.C.R. 2505-10, Section 356.20, a Base Rate is determined as the dollar value to be assigned to a DRG with a relative weight of 1.00. Thus, if a particular patient's discharge diagnosis is assigned a

DRG with a relative weight of 2.00 and the base rate is $1600, the payment to be made to the hospital for the patient's treatment would be equal to two times the base rate, or $3200.

8. Under 10 C.C.R. 2505-10, Section 8.356.20, paragraph 5, a separate Base Rate was determined for each of three different "peer groups" of hospitals: (a) urban hospitals, (b) rural hospitals, and (c) rural referral centers. In addition, a Base Rate is defined for out-of-state hospitals. With the exception of the out-of-state hospitals, the hospitals within each peer group are presumed by the State Medicaid Agency to have similar cost characteristics.

9. The DRG Base Rate for each peer group was calculated through the use of the peer group hospitals' *Medicare* costs per discharge. (The out-of-state hospitals peer group Base Rate is equal to a percentage of the urban hospitals' Base Rate.) Reimbursable *Medicare* costs are determined through "reasonable cost" standards set forth in 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.1 *et seq*. Not all Actual Costs incurred by hospitals are Allowable Costs under these Medicare reasonable cost principles. Moreover, Allowable Costs are only reimbursed to the extent they are reasonable in amount.

10. To calculate the *Medicaid* Base Rate for each peer group under 10 C.C.R. 2505-10, section 8.356.20, an average *Medicare* reimbursable cost per discharge for each peer group is calculated. This average is based on the total costs obtained from the peer group hospitals' most

recently audited Medicare/Medicaid cost reports (currently the 1985 reports) divided by the number of Medicare discharges for each hospital. The *Medicare* Allowable Cost of each hospital are adjusted to neutralize cost differences between hospitals in the peer groups resulting from differences in the severity of the conditions of the *Medicare* patients treated at each hospital. The peer group hospitals' average *Medicare* cost per discharge obtained from the 1985 cost report is updated by an inflation factor (currently approximately 3% per year) to reflect current input prices. A *Medicaid* cost per case adjustment of .88 is then applied to the average Medicare cost per discharge to obtain an average *Medicaid* cost per discharge. In applying the .88 figure, the State Medicaid Agency has assumed that the average costs for treating Colorado *Medicaid* patients are essentially 88% of the average costs of treating *Medicare* patients with the same diagnoses.

11. The State Medicaid Agency did *not* use the resulting Medicaid average cost per discharge as the peer groups' Base Rates by which the DRG relative weights are multiplied to obtain payment rates. Instead, the State Medicaid Agency reduced the average Medicaid cost for each peer group by a final adjustment factor of 46% or more. In other words, the average Medicaid cost per discharge in each peer group was reduced by nearly one-half to obtain the Base Rate for each peer group. The final adjustment factor is based on the sums historically appropriated by the State Legislature for Medicaid payment for inpatient hospital services. There are no exceptions to the application of the final adjustment factor.

12. Not all hospital inpatient services provided to Medicaid patients are subject to the DRG payment

system. For example, if a general acute care hospital provides rehabilitation or psychiatric services in a physically separate part of its hospital (*i.e.*, a "distinct part" unit), the unit is exempt from the DRG payment rates. Under 10 C.C.R. 2505-10, section 8.351.40, a "per diem" rate has been calculated by the State Medicaid Agency for total services (ancillary and routine) rendered in such distinct part units based on the average historical costs of providing Routine Services in such units at all Colorado hospitals. The costs of Ancillary Services are not included in the State's present per diem rate calculations. These per diem rates are only temporary, and may be adjusted retroactively to July 1, 1988.

13. The State Medicaid Agency amended its regulations on December 4, 1987, to incorporate the above-described methods and standards for determining payment rates for inpatient hospital services. The State Medicaid Agency submitted a Medicaid State Plan Amendment to HCFA reflecting the new DRG system in early July 1988. In the State Plain Amendment, the State Medicaid Agency assures HCFA that, *inter alia*, the payment rates produced under the new DRG system comply with all federal requirements, including the Federal Requirement.

14. Plaintiff Hospitals provide inpatient hospital services which are subject to the new DRG payment system. Plaintiff Hospitals also provide services in distinct part psychiatric and rehabilitation units which are subject to the above described per diem rates. With respect to the DRG system, Plaintiff Hospitals are members of the urban hospitals peer group. The actual average Medicaid cost per discharge for the urban peer group

is approximately $3,038. However, because of the application of the final adjustment factor, the current Base Rate for urban hospitals is only 54% of that sum, or $1,630.

15. The Colorado State Legislature has appropriated $57,427,405 for reimbursing inpatient hospital services for the fiscal year beginning July 1, 1988 (*i.e.*, the 1989 fiscal year). Of that sum, approximately $41,000,000 is projected to be paid for hospital services covered by the new DRG system. Another approximately $3,000,000 is projected to be paid for those services provided by general acute care hospitals in distinct part units, such as in Plaintiff Hospitals' psychiatric and rehabilitation units. The remainder of the appropriation is allocated to other categories of services and is not at issue. Because the total sum to be paid for inpatient hospital services is limited to the total sum appropriated by the State Legislature, there will have to be a concomitant decrease in payments to other categories of inpatient hospital services if payments in any category exceed the sums projected, unless the State Legislature appropriates supplemental funds.

16. The State Medicaid Agency has been required to request permission from the Legislature to "overspend" its 1988 fiscal year budget for inpatient hospital services since the sum appropriated for the 1988 fiscal year did not cover the actual amounts required to be paid to providers under the previous system for reimbursing providers of inpatient hospital services. If permission to overspend is granted, the additional funds will be paid out of the 1989 fiscal year appropriation.

17. The amount to be paid by the State Medicaid Agency to all hospital providers exclusive of the

final adjustment factor is projected to exceed $106,000,00 for services provided to Medicaid patients during the 1989 fiscal year. If the number of Medicaid patients exceed projections, this sum would increase. The final adjustment factor of 54% is determined by the ratio of the Legislature's budget appropriation, approximately $57,000,000, to $106,000,000. Thus, in the aggregate, hospitals will receive approximately $57,000,000 for the 1989 fiscal year Medicaid services, unless the State Legislature appropriates a supplemental amount.

C. *Stipulations Regarding Admissibility of Evidence.*

The State Medicaid Agency has no objections to the admission of Plaintiffs' Exhibits 1-13.

Similarly, Plaintiff Hospitals have no objections to the admission of the State Medicaid Agency's Exhibits A and B.

D. *The Applicable Statutes And Regulations.*

Plaintiff Hospitals and the State Medicaid Agency agree that the statutes and regulations governing this dispute are found at 42 U.S.C. § 1396 *et seq.*, 42 C.F.R. § 431 *et seq.*, 42 C.F.R. § 447.250 *et seq.*, 45 C.F.R. § 201 *et seq.*, C.R.S. § 26-4-110, and 10 C.C.R. 2505-10, §§ 8.351 and 8.356. The pertinent provisions of these statutes and regulations are included in the accompanying document entitled "Applicable Statutes and Regulations."

V. *PENDING MOTIONS*

None.

VI. *WITNESSES*

Plaintiff Hospitals intend to call the following witnesses in the following order:

1. James R. Hart
2. Dr. Garry A. Toerber (adverse witness)
3. David West (adverse witness)
4. Kathleen Means

Mr. Hart and Ms. Means will testify as expert witnesses. The State Medicaid Agency stipulates that Mr. Hart is an expert in the area of Colorado hospital costs and that Mr. Means is an expert in health care financing.

Written summaries of the opinions of Mr. Hart and Ms. Means and a description of their qualifications have been provided to the State Medicaid Agency's counsel.

The State Medicaid Agency intends to call the following witnesses in the following order:

1. Dr. Garry A. Toerber
2. David West

All of the above witnesses will be present at trial. It is possible, however unlikely, that the testimony of some of the witnesses will be offered by deposition.

Mr. Hart will testify generally about how payment rates are calculated under the new DRG system and will also speak about the background of the system. Additionally, Mr. Hart will testify regarding the payment rates produced under the new system and the costs of the Colorado hospitals to which the new payment rates are

applicable. Finally, he will give his opinion as to whether the payment rates will meet the costs of any Colorado hospitals.

Dr. Toerber and Mr. West will testify regarding the background and development of the DRG system and will also testify regarding the factors which were and were not considered in connection with developing and implementing the new DRG system and the payment rates produced thereunder. They will also testify regarding the sums appropriated by the Colorado State Legislature with respect to the new system.

Ms. Means will testify regarding HCFA's interpretation of the federal regulations governing the establishment of payment rates for inpatient hospital services and will also generally discuss the procedures by which State Medicaid Agencies are required to establish such payment rates. Additionally, she will comment on the HCFA review process associated with payment rates. Finally, she will give her opinion as to whether the payment rates in question are reasonable and adequate to meet the costs incurred by efficiently and economically operated Medicaid Providers.

VII. *EXHIBITS*

A. Plaintiff Hospitals will offer the following exhibits during trial:

1. The State regulations pertaining to the State Medicaid program, including the regulations implementing the new DRG system, Sections 8.300 through 8.373.4, consisting of 41 pages.

2. Excerpts from the training seminars presented by the Colorado Hospital Association and the State Medicaid Agency regarding implementation of the new DRG system, consisting of 32 pages.

3. A sample Medicare/Medicaid cost report form consisting of 159 pages.

4. The State Fiscal Year 1989 Medicaid Projections, prepared by the State Medicaid Agency on March 29, 1988, consisting of one page.

5. A summary sheet of various calculations relating to the new DRG system prepared by the DRG Advisory Committee, consisting of one page.

6. A Technical Issue Paper for the DRG Advisory Committee, consisting of 2 pages, dated August 21, 1986.

7. The transmittal form and accompanying materials, including the assurances transmitted by the state Medicaid Agency to HCFA with respect to the new DRG system, consisting of 36 pages.

8. The Colorado Hospital Association's calculations of the impact of the DRG system, consisting of two pages.

9. The State Medicaid Agency's June 9, 1988, letter to St. Luke's Hospital with attachments, consisting of 11 pages.

10. The State Medicaid Agency's June 9, 1988, letter to Presbyterian Denver Hospital, consisting of 11 pages.

11. Plaintiff Hospitals' July 6, 1988, letter to the State Medicaid Agency with attachments, consisting of 11 pages.

12. A list of James R. Hart's background and qualifications, consisting of one page.

13. A list of Kathleen Means' background and qualifications, consisting of one page.

14. Any exhibits necessary for impeachment and/or rebuttal.

B. The State Medicaid Agency intends to offer the following exhibits:

1. Chart summarizing appropriations and expenditures for Medicaid inpatient hospital services beginning FY 1984 through projection for the current fiscal year.

2. Rule making record concerning the Colorado Board of Social Services adoption of regulations implementing the new DRG system, sections 8.300 through 8.373.4, including the Statement of Basis and Purpose, Fiscal Impact Statement and Excerpts from the Minutes of the Board's meetings on November 6 and December 4, 1987.

3. Any exhibits necessary for impeachment, rebuttal or to complete excerpts from documents offered in evidence by the Plaintiff Hospitals.

VIII. *DISCOVERY*

All discovery has been completed.

IX. *SPECIAL ISSUES*

None.

X. *OFFER OF JUDGMENT*

Counsel acknowledge familiarity with the provisions of Rule 68, Federal Rules of Civil Procedure (Offer of Judgment) and have discussed it with the client against whom claims are made in this case.

XI. *EFFECT OF PRETRIAL ORDER*

Counsel acknowledge familiarity with the provisions of Rule 16, Federal Rules of Civil Procedure (Pretrial Procedures; Formulating Issues).

Hereafter, this Order will control the subsequent course of this action and the trial and may not be amended except by consent of the parties and approval by the Court or by order of the Court to prevent manifest injustice. The pleadings will be deemed merged herein. In the event of ambiguity in any provision of this Order, reference may be made to the records of the Pretrial Conference, if one is conducted and reported, and to the pleadings.

XII. TRIAL AND ESTIMATED TRIAL TIME

A court trial will be held in this case beginning at 9 a.m. on August 11, 1988. The parties estimate that the trial will last one day.

DATED: August ___, 1988.

Sherman G. Finesilver
United States District Judge

Presented Jointly By:

DAVIS, GRAHAM & STUBBS

/s/ Sharon E. Caulfield
L. Richard Freese, Jr.
Sharon E. Caulfield
370 17th Street, Suite 4700
Denver, Colorado 80201
(303) 892-7308

FOR THE ATTORNEY GENERAL:

/s/ Wade Livingston
Wade Livingston
Vivianne Oates
Office of the Attorney General
for the State of Colorado
1525 Sherman Street, 3rd Floor
Denver, Colorado 80203

Attorney for Defendants

HOOPER, LUNDY & BOOKMAN, INC.

/s/ Patric Hooper
Patric Hooper
Fox Plaza, Suite 430
2121 Avenue of the Stars
Los Angeles, CA 90067-5010
(213) 551-8165

Attorneys for Plaintiffs